STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

APPLICATION FOR LICENSURE

HEALTH FACILITY ADMINISTRATOR

DOPL-AP-027 REV 07/18/2003

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Division desires to provide courteous and timely service to all applicants for licensure. To maximize its efficiency and level of service, the Division will process complete applications only. **A complete application includes all applicable supporting documents and fees.** The fees are for processing your application and will not be refunded. Failure to complete the application and supply necessary information will delay processing and may result in denial of licensure. Please read all instructions carefully.

Address of Record: The address listed on the application will be your address of record. All correspondence from the Division will be sent to that address. It is your responsibility to directly notify the Division of any change in address.

Social Security Number: Your social security number is classified as a private record pursuant to Title 63, Chapter 2, Utah Government Records Access and Management Act (GRAMA). It is used as an individual identifier for our licensing database and for purposes of the child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements the requirements of 42 U.S.C. 666(a)(13). An application that does not include a social security number is incomplete and cannot be processed.

SUPPORTING DOCUMENTS AND FEES:

1. Submit an official transcript documenting a minimum of a baccalaureate degree from an accredited university or college. Have the school mail this documentation to you to include with your application. (To be official, the transcript must bear the school seal.)

   OR

   Submit a "Request for Verification of Qualifying Experience and Competence" form (attached to this application) documenting at least 8,000 hours of qualifying experience.

2. Submit an "Affidavit of Completion of AIT Preceptorship" form (attached to this application) documenting a minimum of 1,000 hours.

3. Submit official verification of your National Association of Boards of Examiners for Nursing Home Administrators (NAB) Examination documenting a minimum passing score of 113.

4. Submit a $120.00 non-refundable application-processing fee.

ADDITIONAL IMPORTANT INFORMATION:

1. **Laws and Rules:** You are required to understand all Utah laws and rules pertaining to your practice. The following applicable laws and rules are available on the Internet at www.dopl.utah.gov.

   - Division of Occupational & Professional Licensing Act
   - General Rules of the Division of Occupational & Professional Licensing
   - Health Facility Administrator Act
   - Health Facility Administrator Act Rules

   You may also purchase them for a fee from Experior, 5486 South 1900 West, Suite C, Taylorsville, Utah 84118, (801) 355-5009.

2. **Current Documents:** Applications, statutes, and rules may change from time to time. If you have not recently obtained any of these documents, you may want to contact the Division or visit our Internet site to verify that you have current versions.

3. **NAB Examination:** Before you may sit for the National Association of Boards of Examiners for Nursing Home Administrators Examination you must be made eligible by the Division. To become eligible, you must submit a complete application for licensure to the Division. Once the Division determines that your application is complete, the Division will send you a letter of approval to test, which will provide you with information about registering for the examination.

4. **Examination Fees:** There are separate fees for all examinations. It is the responsibility of the applicant to submit the fees directly to the testing agency.

5. **License Renewal:** All health facility administrator licenses expire on May 31 of each odd-numbered year.

   Unlike many other states, Utah's license renewal schedule **is not** based on the licensee's date of initial licensure. Under Utah's renewal system, all licenses in each profession expire as a group on the same day every two years. Therefore, the length of a licensee's first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full two years.

Additionally, the fee paid with this application for licensure is an application-processing fee only. It does not include a renewal fee. Each licensee is responsible to renew licensure **PRIOR** to the expiration date shown on the current license. Renewal information is disseminated to each licensee at the licensee's last known address, as provided to the Division, approximately two months prior to the expiration date shown on the license.

6. **Updating Address Information**: It is a licensee responsibility to maintain a current address with the Division. If your address is incorrect, you will not receive renewal notices or other correspondence.

7. **Name Change:** If you have been licensed by the Division under any other name, please submit documentation of your name change such as a copy of your marriage license or divorce decree.

8. **Payments:** Make licensure fees payable to "DOPL."

9. **Mail Complete Application to:**

By U.S. Mail
Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail
Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

10. **Telephone Numbers:** (801) 530-6628

(866) ASK-DOPL – Toll-free in Utah
(866) 275-3675

11. **Fax Number:** (801) 530-6511

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APPLICATION FOR LICENSURE

GENERAL INFORMATION

License Applying For: **Health Facility Administrator**

Social Security Number: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Have You Ever Held A Utah License Before? Yes_____ No_____

If Yes, Name of Profession: _____

If Yes, License Number: _____

Gender (Male or Female): _____ Date of Birth: _____

MAILING ADDRESS

Street: _____

City: _____ State: _____Zip: _____

County: _____

Telephone: _____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: _____

Approved By: _____

Date License/Certificate Denied: _____

Denied By: _____

Reason For Denial/Other Comments: _____

APPLICATION FOR HEALTH FACILITY ADMINISTRATOR BASED UPON:

_____Education

_____Qualifying Experience

EDUCATION REQUIREMENT (Use additional sheets if necessary):

Name: _____ Dates Attended: _____ to _____

Location: _____

Degree Received: _____ Date of Graduation: _____

EXAMINATION REQUIREMENT:

Answer "**Yes**" or "**No**."

_____ National Examination (NAB), Date(s) Taken: _____

LICENSES:

List all licenses, registrations, or certifications issued by any state that you now hold or have ever held. Use additional sheets if necessary.

Issuing State: _____ Profession: _____

License Status: _____ License Number: _____ Effective Date: _____

Issuing State: _____ Profession: _____

License Status: _____ License Number: _____ Effective Date: _____

Issuing State: _____ Profession: _____

License Status: _____ License Number: _____ Effective Date: _____

HEALTH FACILITY ADMINISTRATOR QUALIFYING QUESTIONNAIRE

Answer "**yes**" or "**no**" for each question. Do not leave any question blank.

1. _____ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?

2. _____ Have you ever been denied the right to sit for a licensure examination?

3. _____ Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?

4. _____ Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?

5. _____ Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?

6. _____ Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

7. _____ Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?

8. _____ Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?

9. _____ Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

(Questions continue on following page.)

10. _____ Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?

11. _____ Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?

12. _____ Have you been named as a defendant in a malpractice suit?

13. _____ Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?

14. _____ If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?

15. _____ Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?

16. _____ Have you ever been terminated from a position because of drug use or abuse?

17. _____ Are you currently using or have you recently (within 90 days) used any drugs (including recreational drugs) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?

18. _____ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?

19. _____ Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?

20. _____ Have you ever been arrested for or charged with a misdemeanor in any jurisdiction? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

21. _____ Have you ever been arrested for or charged with a felony in any jurisdiction?

(Questions continue on following page.)

22. _____ Have you ever pled guilty to, no contest to, or been convicted of a misdemeanor in any jurisdiction? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

23. _____ Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?

24. _____ Have you ever been allowed to make a plea in abeyance for any criminal charge for which the charge was later dismissed?

25. _____ Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction?

If you answered "yes" to questions 20, 21, 22, 23, 24, or 25 above, you must include with your application a copy of the police report, court docket, any probation/parole officer report, and a narrative of the circumstances that occurred for EACH and EVERY arrest and/or conviction.

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

If you answered "yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A "yes" answer does not necessarily mean you will not be granted a license; however, the Division may request additional documentation if the information submitted is insufficient.

AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division in conjunction with this application or its supporting documents meet the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant: _____

Date of Signature: _____

Printed Name of Applicant: _____

Division of Occupational & Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Fax: 801-530-6511

REQUEST FOR VERIFICATION OF QUALIFYING EXPERIENCE AND COMPETENCE

TO BE COMPLETED BY APPLICANT:

Name: _____

Complete Street Address: _____

Health Facility Name: _____

Health Facility Address: _____

Name of Administrator: _____ Telephone: _____

Dates of Employment: from _____/_____/_____ to _____/_____/_____

Position Title: _____

Duties, tasks, responsibilities, and percentage of time: (Use additional sheets if necessary.)

_____

_____

_____

_____

_____

_____

I have fulfilled _____ hours of qualifying experience in the licensed health care facility named above. I had responsible fulltime managerial or administrative responsibility for all or part of the operation of the health facility.

Applicant Signature: _____ Date: _____

TO BE COMPLETED BY HEALTH FACILITY ADMINISTRATOR:

The applicant listed on the front of this page has applied for Utah licensure as a health facility administrator. Please complete the information below and return this form to the applicant in a sealed envelope for submission with his/her application for licensure.

Answer "**Yes**" or "**No**."

_____ Do you agree with the information listed on the reverse side of this page from the applicant?

_____ Would you re-hire the applicant?

General Work History: (Choose One.)

_____ Outstanding

_____ Exceeded Requirements

_____ Met Requirements

_____ Needed Improvement

_____ Unsatisfactory

Answer "**Yes**" or "**No**."

_____ Would you recommend this applicant for Utah licensure as a health facility administrator? If "no," indicate reason(s). (Use additional sheets if necessary.)

_____

_____

_____

_____

_____

I have reviewed the information on both sides of this form and attest it is accurate and truthful.

Signature: _____ Date: _____

Name: _____ Title: _____

License Number: _____ State of Licensure: _____

Division of Occupational & Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Fax: 801-530-6511

AFFIDAVIT OF COMPLETION OF AIT PRECEPTORSHIP

TO BE COMPLETED BY AIT APPLICANT:

Name of AIT Applicant: _____

Name of Preceptor: _____

Preceptor's License Number: _____

Date of Licensure: _____ State of Licensure: _____

Facility Name: _____

Telephone: _____

Facility Address: _____

I have reviewed all the information included in this document and in the "Log of Required AIT Training" and certify that it accurately covers my AIT preceptorship experience.

Signature: _____

Date: _____

TO BE COMPLETED BY THE AIT PRECEPTOR:

I certify that I am a licensed health facility administrator in good standing and have been the preceptor for the AIT applicant named above, and that I have personally supervised the AIT training program for the applicant for licensure as a health facility administrator. I further certify that this supervision was on a personal basis and that the AIT under my supervision fulfilled the AIT preceptorship as listed in this document and as outlined in the current Utah laws and rules.

Signature: _____

Date: _____

LOG OF REQUIRED AIT TRAINING

Dates of AIT Preceptorship: from _____/_____/_____ to _____/_____/_____

Total Number of Hours In Patient Care: _____

Total Number of Hours In Personnel Management: _____

Total Number of Hours In Financial Management: _____

Total Number of Hours In Marketing and Public Relations: _____

Total Number of Hours In Physical resource Management: _____

Total Number of Hours In Laws and Regulatory Codes: _____

Total Hours of AIT Preceptorship: _____

Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
FAX: 801-530-6511

REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state, if applicable.)

TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to the state that is verifying information for you. Request that the verifying state complete the form and return it to you for submission with your application. If a verifying state insists on submitting the verification directly to the Division, indicate that fact in the appropriate section of the application.

Applicant Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

I am requesting licensure in the state of Utah as a Health Facility Administrator

I am/have been licensed in your state under the name _____

My social security number is _____

My date of birth is _____

My license number in your state is/was _____

I have enclosed the necessary license verification fee in the amount of $ _____

Signature of Applicant: _____

(Continued on the reverse.)

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail or fax it directly to the Division or place the completed form in a sealed envelope, and provide it to the applicant in person or by mail. The applicant will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (as it appears in verifying state's records): _____

Classification of License Issued: _____

License Number: _____ Current Status: _____

Original Date of Licensure: _____ Expiration Date: _____

Continuously Licensed:

_____ Yes _____ No, please explain: _____

Licensed By:

_____ Exam, Type: _____ Date: _____

_____ Endorsement, from what state? _____

_____Waiver: _____

Examination Scores: _____

Education Required For Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

_____No _____Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____ Title: _____

Agency: _____

Date: _____

(SEAL)